Medicare HMOs

edicare HMOs are health maintenance or-nizations, health care contractors, coordi-ted care, or managed care medical plans at have entered into a "risk-sharing" con-ct with the **Health Care Financing Admin-ration (HCFA).**

ese organizations are paid a **per-member** e each month to deliver all Medicare and edicare supplement insurance benefits for of their members' medical needs.In most ates, there are several organizations that e authorized to offer member benefits un-r such contracts with HCFA.

embers of risk-sharing plans will have eir Medicare benefits and supplemental verage administered by a risk-sharing con-ctor. The contractors either employ their vn medical staffs or contract with outside oviders to care for their members.

is type of plan may offer medical care with deductibles, no claim forms, $5 or $10 fice visits, X-rays, lab work and 100% paid spitalization.
me plans may also provide benefits be-nd what Medicare pays for, such as:

preventive care
vision screenings and eyeglasses
prescription drugs.

ere usually are no additional charges - matter how many times you visit the doc-, are hospitalized or use other covered ser-es.

ADVANTAGES

People join managed care plans for several reasons. Some of the most frequently mentioned include:

➢ **It's generally easier** to get medical services through one source (for example, doctors' services, hospital care, lab tests, X-rays, etc.)

➢ **Quality of care** may be enhanced because of the coordination of services.

➢ **You can more easily budget** health care costs because you know the amount of any premiums in advance, and the total of other out-of-pocket expenses is likely to be less than under the fee-for-service system.

➢ You generally **pay only a nominal copayment** when you use a service. Some plans do not charge copayments for certain specified services.

Most Medicare beneficiaries are eligible for enrollment in this type of managed care plan if one is available in their location. Many plans, including HMOs,Coordinated Medical Plans (CMPs), and other managed care plans, are under contract with the federal government to serve Medicare recipients.

ENROLLMENT REQUIREMENTS

Managed care plans with risk-sharing Medicare contracts have a specific number of enrollments allotted to them. Federal law requires a 30-day open enrollment period each year to allow new members to join the plan, unless the plan is "full." Once the plan is full, no new enrollments can be taken.

Plans cannot screen their applicants to find out if they are healthy or delay coverage for a pre-existing condition. The only enrollment requirements are:

❶ You must at least be enrolled in both parts of Medicare (A & B) and continue to pay the Part B monthly premium. If you are enrolled in Medicare Hospital Insurance (Part A) the plan will provide both Part A and Part B services;

❷ You must live within the plan service area;

❸ You cannot have elected care from a Medicare-certified hospice, and;

❹ You cannot be medically determined to have end-stage renal disease.

If conditions develop after you join a coordinated care plan, and hospice services are needed, or you are medically determined to have end-stage renal diseases, the plan is required to provide or arrange for your care.

DISADVANTAGES

☒ **No continuous or guaranteed renew ability:** Coverages offered by risk-sharin contractors are not guaranteed renewable continuously renewable. But, HCFA regul tions do not allow Medicare-approved or fe erally approved HMOs to make maj changes to their structure or operation wit out federal approval. These approved pla cannot move out of an area or cease oper tions without arranging for supplemental co erage to members who return to fee-for-se vice coverage.

☒ **Members are "locked in"** with risk-sha ing contractors. This means that only ca provided by the contractor or one of i participating providers will qualify for Me care payments.
The only exceptions:

➲ Emergency services;
➲ Out of area urgently needed care;
➲ Use of an outside specialist when t specialty is not available within the provider's network (a patient mus be referred by the primary physicia with approval of the HMO).

☒ **If a member goes outside t** contractor's network of participating provi ers for non-emergency care, he or she w receive **NO MEDICARE PAYMENT** for tho services.

his has two consequences:

If a member uses an "outside" provider r an emergency service, he or she must turn to a participating provider for follow- care.

or example, if a person has a heart at- ck while on vacation and uses a non-par- ipating hospital's emergency room, the k-sharing contractor will pay Medicare d supplemental benefits for the emer- ncy services, but any follow-up care ould require the member to return to a rticipating provider to receive Medicare Medicare supplemental coverage.)

Since Medicare supplement policies pay ntingent on the medical service being alified for Medicare reimbursement, risk- aring contract plans (such as some HMOs), n't use the reimbursement system; there- re, Med-Sup policies won't pay benefits to licyholders who belong to a risk-sharing ntractor/HMO. In other words, if a person a member of a risk-sharing contractor or- nization, and that person also has an ad- tional Medicare supplement policy sepa- te from the risk-sharing contractor's, the licyholder will not be able to claim ben- its under that additional policy.

Going outside the plan for services dis- alifies the member for Medicare benefits r those services and for the companion edicare supplement plan coverage, regard- ss of the carrier.

!!ATTENTION!!

A member can find him/herself disenrolled for several reasons:

☒ **If the member leaves** the contractor's area for 90 days or more.

☒ **HCFA can cancel its contract** with the risk-sharer or the risk-sharer can cancel its contract with HCFA, leaving all members disenrolled and without Medicare supplemental coverage.

☒ **It can take several months** to deliver Medicare reimbursements to recently disenrolled members. These members must pay Medicare covered costs out-of-pocket until Medicare's payment system catches up with them.

☒ A risk-sharing contractor may choose not to renew membership for reasons other than nonpayment of premiums or material misrepresentation. Only risk-sharing contractors are allowed to do this. However, they may not "screen out" enrollees purely on medical grounds.

☒ **Members may be disenrolled "for cause"**: that is, for disruptive and uncooperative behavior, or for making a threat to the contractor.

☒ Members may also be disenrolled for **moving outside the HMO's service area.**

There are currently four HMOs that each have **RISK-SHARING CONTRACTS** with the Health Care Financing Administration in Washington, D. C. and have been approved for sale by the Louisiana Department of Insurance. For further information and areas of coverage please contact:

COMMUNITY HEALTH NETWORK OF LA.
1-800-243-0065

OCHSNER HEALTH PLANS
1-800-999-5979

GULF SOUTH HEALTH PLANS, INC.
(504) 237-1900

ADVANTAGE HEALTH PLANS, INC.
1-800-880-4465

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Medicare Health Maintenance Organizations

An Alternative to Medicare and Medicare Supplement Insurance

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